

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 http://www.dail.vermont.gov

Survey and Certification Voice/TTY (802) 241-0480 Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 24, 2019

Ms. Catherine Rooney, Manager Harvey House Ltd 1860 Main Street Castleton, VT 05735-7709

Dear Ms. Rooney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 30, 2019.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN

Jamela MCotaRN

Licensing Chief

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G:	(X3) DAYE SURVEY COMPLETED
		0380	B. WING		R-C 07/30/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY	, STATE, ZIP CODE	
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	was conducted by the	isite revisit from 4/22/2019 ne Division of Licensing on ere additional regulatory uring the revisit.			
R136 SS≭D	V. RESIDENT CARI	E AND HOME SERVICES	R136	R136 P1	89
	5.7. Assessment		•	The new	1 ^ ^ . ()
;	annually and at any	shall also be reassessed point in which there is a nt's physical or mental		Beth Quinn reviewed is scheduling to do all as	g dater tim
•	by: Based on staff interv facility failed to ensul assessment was cor	T is not met as evidenced iew and record review the re that an annual appleted for one (1) out of five ent # 2) findings include:		on the res She will be each mon given us he after hospi she said the	Lp and pare
	assessment due in A Nurse had completer	esident #2 had an annual pril, 2019. The Registered d an assessment dated to complete one in April,		the next 2	merks
:	Manager confirmed t should have been do	V2019 at 10:15 the facility hat an annual assessment ne in April, 2019, and that it ted per requirements.		month Twill month Twill records to be nowse has	xereach checkthe escripthe isitedait
SS=D		AND HOME SERVICES	R145	not contact I	
on of Lice	Insing and Protection	NSUPPLIER REPRESENTATIVE'S SIGN			DEIMELE
·	COLL.	RISUPPLIER REPRESENTATIVE'S SIG		manage	(XG) DATE

R136-R193 POL accepted 10/23/19 PMateRN

	NT OF DEFICIENCIES FOR CORRECTION	(X1) PROVIDER/SUPPLIER/ČLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
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R145	each resident that is as identified in the nof care must describ necessary to assist independence and v. This REQUIREMEN by: Based on staff intentificable failed to ensure had been developed residents (Resident Per record review, R 3/5/19 and discharge 20 days later. S/he v.	ent of a written plan of care for based on abilities and needs esident assessment. A plan be the care and services the resident to maintain well-being; IT is not met as evidenced view and record review the re that a written plan of care if for one (1) of five (5) # 1). Findings include: desident #1 was admitted on edit to the hospital on 3/25/19, was readmitted on 4/9/19. In the record that a plan of	R145	The horse is do the corre needed 5 re ones alreo place so all up to by the e	plans e assesth dy in they are date nd of useek
	facility Manager cont should have been de	n 7/30/2019 at 10:15, the firmed that a plan of care eveloped, and that the id failed to oversee the plan of care.			
R146 SS=D	V. RESIDENT CARE	AND HOME SERVICES	R146		
	5.9.c (3)				
	care personnel regar	nd supervision to all direct ding each resident's health tional needs and delegate			

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STATE FORM

If continuation sheet, 2 of 9

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with the Medication Delegate, confirmation was made that the Registered Nurse had not been notified of the falls and that there has been no instruction or supervision from an RN regarding Resident # 1's falls and change in condition. {R163} V. RESIDENT CARE AND HOME SERVICES (R163) SS=D 5.5 Medication Management 5.10.d If a resident requires medication		m Vesident # 12 cot	nargon.		1	
with the Medication Delegate, confirmation was made that the Registered Nurse had not been notified of the falls and that there has been no instruction or supervision from an RN regarding Resident # 1's falls and change in condition. {R163} V. RESIDENT CARE AND HOME SERVICES (R163) SS=D 5.5 Medication Management 5.10.d If a resident requires medication		Based on interview of	on 7/30/2019 at 10:30 AM		1	
notified of the falls and that there has been no instruction or supervision from an RN regarding Resident # 1's falls and change in condition. {R163} V. RESIDENT CARE AND HOME SERVICES (R163) SS=D 5.5 Medication Management 5.10.d If a resident requires medication		with the Medication I	Delegate, confirmation was		! !	
Resident # 1's falls and change in condition. {R163} V. RESIDENT CARE AND HOME SERVICES (R163) SS=D 5.5 Medication Management 5.10.d If a resident requires medication		made that the Regis	tered Nurse had not been		<u> </u>	
Resident # 1's falls and change in condition. {R163} V. RESIDENT CARE AND HOME SERVICES (R163) SS=D 5.5 Medication Management 5.10.d If a resident requires medication		nouned of the falls a	nd that there has been no			
 {R163} V. RESIDENT CARE AND HOME SERVICES (R163) 5.5 Medication Management 5.10.d If a resident requires medication 		Resident # 1's falls a	and change in condition			
5.5 Medication Management 5.10.d If a resident requires medication		•	J - · · · · · - · · · · ·			
5.10.d If a resident requires medication	(R163) SS=D	V. RESIDENT CARE	EAND HOME SERVICES	(R163)		
		5.5 Medication Mana	agement			
vision of Licensing and Projection	. •	5,10.d If a resident r	equires medication	į		
	ivision of the	cension and Protection				

If continuation sheet 3 of 9

STATE FORM

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUI! DING	LE CONSTRUCTION	. (X3) DATE SURVEY COMPLETED
			A. DOI: DAVE		R-C
		0380	B. WING		07/30/2019
NAME OF	PROVIDER OR SUPPLIER	(0)1162170		STATE, ZIP CODE	
HARVE	HOUSE LTD		IN STREET TON, VT 057	25	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES			
PREFIX TAG	(EACH DEFICIEN(CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPI
(R163)	Continued From p	age 3	(R163)		
	administration, unl	licensed staff may administer		The horse	has heft
	mr'dications under	the following conditions:	12163	The Ro	•.
	(1) A registered w		المراج المساء	inservicetr	OIKING S
	(i) miegistereg fil assessment conci-	urse must conduct an stent with the physician's		1000000	(L)
	diagnosis and orde	ers of the resident's care needs		f 15 schied	i i nig
	as required in sect	ion 5.7.c		with each	oude
	This REQUIREME	NT is not met as evidenced		for their	medica
	by:				
	Based on record re	eview and staff interview the		pass testi	NA DX
	(PM) conducted on	sure that a Registered Nurse assessment consistent with		the end o	f this
:	the physician's diad	gnosis and orders of the	:	me end	1 1 16/03
	resident's care nee	eds for one (1) of five (5)		month	₩.
•	residents (Residen	t #2). Findings include:			·
				every 3rd wo	oeka.
	Per record review,	the RN completed an	1	month Ties	110/000
	assessment on 4/3	0/2018. An annual			
	2019 There was no	I have been completed in April, o evidence of an annual	J	that the ins	22109.24
	assessment in the	record	ĺ		
	- TO SO VINGING IN LINE	1000/u.		fraining ha	meed &
	Per interview with the	he facility Manager on		completed	
•	7/30/2019 at 10:15	AM, confirmation was made		7	
	that the Registered	Nurse should have conducted	;		
	an annual assessm	ent in April, 2019, and that	}		
	assessment had be	nce in the record that the een conducted.	j		
R164 SS=D	V. RESIDENT CAR	E AND HOME SERVICES	R164		
	5.10 Medication M	anagement			
	5.10.d If a resident i	requires medication	į		
	administration, unlic	ensed staff may administer	į į		
1	medications under t	he following conditions:	;		

STATE FORM

If continuation sheet, 4 or 9

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ČLIA IDENTIFICATION NUMBER	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0380	8. WING		R-C 07/30/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY,	STATE, ZIP CODE	
HARVEY	HOUSE LTD	i i	IN STREET TON, VT 057	735	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE
R164	Continued From pa	ge 4	R164		
:	her ponsibility for the	rse must delegate the a administration of specific gnated staff for designated			
:	by: Based on staff inter facility failed to ensi (RN) detegated the administration of sp	view and record review, the ure that a Registered Nurse responsibility for the ecific medications for one (1) (Resident #1). Findings	P.Val-	d 11121	Y
	Registered Nurse h made to Resident # therefore has not de	here is no evidence that the as been notified off changes 1's medication orders, elegated the responsibility for f specific medications.		completed end of Su every 3rd wo	eer I
	7/30/2019 at 11:20 / that staff do not not physicians orders for Medication Delegate medications S/he a contact the facility M when new medication	te medication delegate on AM, confirmation was made fy the RN when they receive in new medications, or when as administer as needed laso confirmed that staff lanager (who is not an RN) on orders are received, and edications are administered.		will review sore nors reviewed records	e has
(R165) SS=D	V. RESIDENT CARI	E AND HOME SERVICES	{R165}		
	5.10 Medication Ma	nagement .			
	5.10.d If a resident administration, unlice medications under the	regulres medication ensed staff may administer ne following conditions:			

If continuation sheet, 5 of 9

Division of Licensing and Protection

STATE FORM

Division of Licensing and Pr STATEMENT OF DEFICIENCIES		1 1000		FORM APPROVE
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED
	0380	B. WING		R-C
NAME OF PROVIDER OR SUPPLIER				07/30/2019
The state of the state of soffice	,	ODRESS, CITY, S	IATE, ZIP CODE	
HARVEY HOUSE LTD		NN STREET TON, VT 0573	35	
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETE
(R165) Continued From pa	age 5	{R165}		
restionsibility for the medications, and is i. Teaching designer medication admirate appropriate in condition, relevant side effects; ii. Establishing a communication with resident's condition as well as changes iii. Assessing the need for any change Monitoring and eva	gnated staff proper techniques ninistration and providing formation about the resident's medications, and potential process for routine h designated staff about the and the effect of medications.			
by: Based on observation record review the far process for routine registered nurse and resident's condition one (1) of five (5) refindings include: On 7/30/2019 at 10 floor while attemption that the process for routing an interview Resident #1 stated and falling and that of his/her medication.	Resident #1 has had six (6) th of July, 2019. S/he is on			
	s that have the potential to of dizziness, low blood			
rision of Licensing and Protection				
ATE FORM		851	/712	If continuation sheet 6 of

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY MPLETED
		0380	B WING			R-C /30/2019
NAME OF F	PROVIDER OR SUPPLIER	√ \$TREETA	DDRESS, CITY, S	TATE, ZIP CODE		
HARVEY	HOUSE LTD	:	IN STREET TON, VT 0573	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES '. Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
(R165)	Centinued From pa	age 6	{R165}			
	ev dence in the rec has been made aw	iac changes. There is no ord that a Registered Nurse are of Resident #1's change possible need for changes in				
	7/30/2019 at 11:20 the Registered Nur of Resident #1's ch possible need for c also confirmed that	he Medication Delegate on confirmation was made that se had not been made aware lange in condition or the hanges in medications. S/he the Registered nurse is not sident falls, is sick, or injured.		·		
(R189) SS=D		RE AND HOME SERVICES	{R189}		•	
	5.12.b. (3)	,				•
	nursing overview or record shall also co annual reassessme assessment; physic and current orders; changes in the resi- taken; and reports of	ring nursing care, including r medication management, the ontain: initial assessment; ent; significant change cian's admission statement staff progress notes including dent's condition and action of physician visits, signed not treatment documentation; f care.				
	by: Based on staff inter facility failed to ensi contained an annual	NT is not met as evidenced review and record review the ure that the resident record at assessment for one (1) of Resident #2). Findings include:				
		the most current assessment 4/30/2018. There was no				

Nicontinuation sheet 7 of 9

STATE FORM

PRINTED: 08/09/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0380	B. WING		R-C 07/30/2019
NAME OF PROVIDER OR SUPPLIE	R STREETAL	DRESS, CITY,	STATE, ZIP CODE	
HARVEY HOUSE LTD		N STREET	•	•
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· · · · · · · · · · · · · · · · · · ·	TON, VT 057		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICENCY)	D BE COMPLETE
	nnual assessment being	(R189)		
Per interview with 7/30/2019 at 10:1 annual assessme in April, 2019, an	of the facility manager on the facility manager on SAM, s/he confirmed that an an the should have been completed that there was no evidence assessment was completed per			
R193: V. RESIDENT CA SS=D	ARE AND HOME SERVICES	R193	There is an	ee
Equipment and s for universal prec and for care of m contusions, and s shall be readily a This REQUIREM by: Based on observe interview, and rec provide equipment residents needs f (Resident #1) in of Findings include: On 7/30/2019 at floor while attemp Resident #1 state standing causing	uipment and Supplies uch supplies as are necessary autions, to meet resident needs inor cuts, wounds, abrasions, imilar sudden accidental injuries vailable and in good repair. ENT is not met as evidenced ation, resident and staff ford review the facility failed to no necessary to meet the or one (1) of five (5) residents order to monitor blood pressure. 10:25 AM, Resident #1 fell to the othing to stand from a chair. d that s/he became dizzy while the fall. I incident reports, Resident #1 7/15, 7/18, 7/25, and 7/29/2019	:	There is an M BP machine along with a for wound down 9/20/19	onsite replies
while standing or reflects that the re	ambulating. Documentation esident reported to staff that he dizzy and unsteady causing him			·

Division of Licensing and Protection

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If continuation sheet 8 of 9

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Division of Licensing and Prestatement of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	}	CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	0380	8. WING		•	R-C 07/30/2019
NAME OF PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	TATE, ZIP CODE		
HARVEY HOUSE LTD		UN STREET TON, VT 0573	5		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES ' Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOUL O THE APPROI	DSE COMPLE
R193 Continued From pa	age 8	R193			
on 7/30/2019 at 11, the resident's blood monitored, and tha	with the medication delegate 20 AM, s/he confirmed that pressure should be tequipment used to monitor				
blood pressure was	s not available to staff.				:
					, ;
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